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Oregon Chapter, American College of Emergency Physicians (O.C.E.P)

Testimony before the House Health Care Committee
February 08, 2017
HB 2114 Opiate Prescribing Practices

Chair Greenlick and members of the committee, my name is Hans Notenboom, MD, and I'm the President of the Oregon Chapter of the American College of Emergency Physicians. OR-ACEP is a medical society that has represented physicians specializing in emergency medicine since 1971 and its members share a commitment to improve emergency healthcare for all Oregonians.

In the U.S. and in Oregon, we're facing a prescription opioid abuse epidemic and emergency physicians see first-hand the toll these drugs take on individuals, families and communities. I wanted to provide background on efforts the chapter has undertaken over the last several years to address the opioid crisis in Oregon. While we share the goal of HB 2114, passing prescribing limits isn't going to correlate to the outcomes you want to get. Emergency physicians need to look at diverse populations, provide acute care for conditions that could be life-threatening and use they best judgment when treating pain, following all legal and ethical guidelines. Our shared goal should look also at appropriateness and coordination of care.

OR-ACEP supports evidence-based, coordinated pain treatment guidelines that promote adequate pain control, health care access and flexibility for physician judgment. OR-ACEP, in coordination with ACEP, the Washington chapter of ACEP and national partners such as the AMA, CDC, FDA and others, has been educating its members and the public on safe prescribing guidelines for a number of years and the efforts have already shown great success. Prescriptions written from emergency departments account for less than 4.7% of opioids prescribed. According to a 2015 American Journal of Preventative Medicine (AJPM) study, the largest percentage drop in opioid-prescribing rates between 2007-2012 occurred in emergency medicine (-8.9 percent). Furthermore, emergency physicians focus on managing acutely injured and ill patients and rarely prescribe

extended release opioids or prescriptions for more than several days (following our own OR-ACEP guidelines).

The chapter has also been active partners in supporting and implementing the Emergency Department Information Exchange, supporting legislation to improve the Prescription Drug Monitoring Program and naloxone prescriptions, serving on opioid task forces at the state and national level and prioritizing appropriate patient care. We appreciate the commitment of Chair Greenlick and other partners to address the opioid crisis and respectfully request the opportunity to be part of conversations to move that effort forward.

Attachment: OR-ACEP Opioid Prescription Guidelines

Opioid Prescription Guidelines
Publication Date:
Friday, April 22, 2016
Oregon Emergency Department (ED) Opioid Prescribing Guidelines

1 One medical provider should provide all opioids to treat a patient's chronic pain, to the extent possible.
2 The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
3 Emergency medical providers (EMPs) should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
4 EMPs should not provide replacement doses of methadone for patients in a methadone treatment program.
5 Long-acting or controlled-release opioids (e.g., OxyContin®, fentanyl patches and methadone)
6 should not be prescribed from the ED.
7 EMPs are strongly encouraged to register for the online Oregon Prescription Drug Monitoring Program (PDMP), and access the PDMP when considering prescribing opioids to appropriate patients.
8 EMPs should exercise caution when considering prescribing opioids for patients who present to the ED without a government issued photo ID.
9 Primary care and pain management physicians should make patient pain agreements accessible to local EDs and work to include a plan for pain treatment in the ED.
10 EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program, to the extent possible.
11 EDs should maintain a list of clinics that provide primary care for patients of all payer types, and should refer patients with chronic pain to primary care.
12 EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse.
13 The administration of Demerol® (Meperidine) in the ED is discouraged.
14 For exacerbations of chronic pain, the EMP should contact the patient's primary opioid prescriber or pharmacy, if possible. If prescribing, the EMP should only prescribe enough pills to last until the patient is reasonably able to follow up with his or her primary opioid prescriber.
15 Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, should be in an amount that will last until the patient is reasonably able to receive follow up care for the injury. In most cases, this should not exceed thirty (30) tablets.

16 ED patients should be asked about a history of or current substance abuse prior to the EMP prescribing opioid medication for acute pain. Opiates should be prescribed with great caution in the context of substance abuse.
17 EMPs should avoid prescribing opioids and benzodiazepenes simultaneously, as this combination can lead to greater risk of adverse events.
18 EMPs are required by law to evaluate an ED patient who reports pain, and determine whether an emergency medical condition is present. If an emergency medical condition is present, the EMP is required to stabilize the patient's condition. The law allows the EMP to use his or her clinical judgment when treating pain, and does not require the use of opioids.

Note: EMPs should be supported and should not be subject to adverse consideration when respectfully adhering to these guidelines.

Disclaimer: This document should not be used to establish any standard of care. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct. These guidelines are only an educational tool. Clinicians should use their own clinical judgment and not base clinical decisions solely on this document. The following recommendations are not founded in evidence-based research but are based on promising interventions and expert opinion. Additional research is needed to understand the impact of these interventions on decreasing unintentional drug poisoning and on health care costs. All of the following recommendations should be implemented in concert and collaboration with public health entities and other relevant stakeholders.